

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042010

Facility Name: Alden Des Plaines Rehab & HC

Address: 1221 East Golf Road Des Plaines 60016
Number City Zip Code

County: Cook

Telephone Number: (847) 768-1300 Fax # (847) 768-1668

IDPA ID Number: 36-4271650

Date of Initial License for Current Owners: 10/31/2000

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll Telephone Number: (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Joan Carl

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	1,534	5,262	20,745	27,541	8
9	SNF/PED					9
10	ICF	31	1,315		1,346	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,565	6,577	20,745	28,887	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.75%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 10/31/2000

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/31/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 85 and days of care provided 20,745

Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	517,512	27,578	6,967	552,057	996	553,053		553,053			1
2	Food Purchase		213,103		213,103	(19,398)	193,705	(7,025)	186,680			2
3	Housekeeping	92,958	17,971		110,929	1,240	112,169		112,169			3
4	Laundry	37,518	11,829		49,347	19	49,366		49,366			4
5	Heat and Other Utilities			184,630	184,630		184,630	(3,242)	181,388			5
6	Maintenance	39,669		126,724	166,393	131	166,524	4,084	170,608			6
7	Other (specify):* Relatd party salary			137	137		137	21,363	21,500			7
8	TOTAL General Services	687,657	270,481	318,458	1,276,596	(17,012)	1,259,584	15,180	1,274,764			8
	B. Health Care and Programs											
9	Medical Director			54,067	54,067		54,067		54,067			9
10	Nursing and Medical Records	2,010,330	163,212	16,773	2,190,315	5,683	2,195,998	(83,126)	2,112,872			10
10a	Therapy	92,015			92,015		92,015		92,015			10a
11	Activities	92,883	1,457	5,513	99,853	117	99,970		99,970			11
12	Social Services	40,678			40,678		40,678		40,678			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Relatd party salary							15,975	15,975			15
16	TOTAL Health Care and Programs	2,235,906	164,669	76,353	2,476,928	5,800	2,482,728	(67,151)	2,415,577			16
	C. General Administration											
17	Administrative	124,834			124,834		124,834		124,834			17
18	Directors Fees											18
19	Professional Services			954,187	954,187		954,187	(774,267)	179,920			19
20	Dues, Fees, Subscriptions & Promotions			53,887	53,887		53,887	(47,177)	6,710			20
21	Clerical & General Office Expenses	270,423	22,189	62,719	355,331	486	355,817	(31,447)	324,370			21
22	Employee Benefits & Payroll Taxes			513,013	513,013	10,726	523,739	(19,494)	504,245			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,289	9,289		9,289	6,898	16,187			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,031	96,031		96,031	13,231	109,262			26
27	Other (specify):* Relatd party salary			19,719	19,719		19,719	209,718	229,437			27
28	TOTAL General Administration	395,257	22,189	1,708,845	2,126,291	11,212	2,137,503	(642,538)	1,494,965			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,318,820	457,339	2,103,656	5,879,815		5,879,815	(694,509)	5,185,306			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			61,236	61,236		61,236	231,083	292,319			30
31	Amortization of Pre-Op. & Org.							915	915			31
32	Interest			167,857	167,857		167,857	517,716	685,573			32
33	Real Estate Taxes							280,361	280,361			33
34	Rent-Facility & Grounds			1,297,630	1,297,630		1,297,630	(1,297,630)				34
35	Rent-Equipment & Vehicles			16,639	16,639		16,639	11,579	28,218			35
36	Other (specify):* MIP & Amort							45,920	45,920			36
37	TOTAL Ownership			1,543,362	1,543,362		1,543,362	(210,056)	1,333,306			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,044,713	1,459,676	2,504,389		2,504,389	(430,144)	2,074,245			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		294		294		294	(294)				41
42	Provider Participation Fee			60,390	60,390		60,390		60,390			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,045,007	1,520,066	2,565,073		2,565,073	(430,438)	2,134,635			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,318,820	1,502,346	5,167,084	9,988,250		9,988,250	(1,335,003)	8,653,247			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(90,936)	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,836)	2		13
14	Non-Care Related Interest	(53,698)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(912)	21		17
18	Fines and Penalties	(750)	32		18
19	Entertainment	(2,817)	20		19
20	Contributions	(1,777)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,069)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,718)	27		24
25	Fund Raising, Advertising and Promotional	(40,804)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(212)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (218,733)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(731,035)	Various	34
35	Other- Attach Schedule	(385,235)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,116,270)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,335,003)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Late fees on utilities	\$ (4,825)	5 1
2	Gift shop expenses (gl 6944)	(294)	41 2
3	Intercompany (AMS) interest (gl 7031)	(7,432)	32 3
4	Misc income (gl 4977) (jury duty)	(34)	21 4
5	IL Health Care Assoc dues (PAC 31.78%)	(1,845)	20 5
6	Marketing Mgr (gl 6701-100-009)	(126,302)	21 6
7	Mktg Mgr employee benefits reduction	(19,494)	22 7
8	Back out vendor settlement cost for prior yr	(1,442)	21 8
9	Back out LLC mtge int > CON asset limit	(206,643)	32 9
10	Back out LLC MIP exp > CON asset limit	(17,347)	36 10
11	Adj deferred maintenance exp to equal page 22's	715	6 11
12	Back out LLC bank charges	(292)	21 12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(385,235)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,836)	0	0	(5,189)	0	0	0	0	0	0	0	(7,025)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,825)	0	1,583	0	0	0	0	0	0	0	0	(3,242)	5
6	Maintenance	715	0	4,729	0	0	0	(16)	(1,344)	0	0	0	4,084	6
7	Other (specify):*	0	0	21,363	0	0	0	0	0	0	0	0	21,363	7
8	TOTAL General Services	(5,946)	0	27,675	(5,189)	0	0	(16)	(1,344)	0	0	0	15,180	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(73,958)	(9,168)	0	0	0	0	0	0	(83,126)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	15,975	0	0	0	0	0	0	0	0	15,975	15
16	TOTAL Health Care and Programs	0	0	15,975	(73,958)	(9,168)	0	0	0	0	0	0	(67,151)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,069)	3,950	(773,148)	0	0	0	0	0	0	0	0	(774,267)	19
20	Fees, Subscriptions & Promotions	(47,455)	0	278	0	0	0	0	0	0	0	0	(47,177)	20
21	Clerical & General Office Expenses	(128,982)	1,703	17,925	57,145	20,762	0	0	0	0	0	0	(31,447)	21
22	Employee Benefits & Payroll Taxes	(19,494)	0	0	0	0	0	0	0	0	0	0	(19,494)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,898	0	0	0	0	0	0	0	0	6,898	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	13,078	153	0	0	0	0	0	0	0	0	13,231	26
27	Other (specify):*	(19,718)	0	183,854	13,404	32,178	0	0	0	0	0	0	209,718	27
28	TOTAL General Administration	(220,718)	18,731	(564,040)	70,549	52,940	0	0	0	0	0	0	(642,538)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(226,664)	18,731	(520,390)	(8,598)	43,772	0	(16)	(1,344)	0	0	0	(694,509)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(90,936)	311,477	9,144	0	1,398	0	0	0	0	0	0	231,083 30
31	Amortization of Pre-Op. & Org.	0	0	915	0	0	0	0	0	0	0	0	915 31
32	Interest	(268,727)	753,844	25,946	0	1,489	5,164	0	0	0	0	0	517,716 32
33	Real Estate Taxes	0	275,153	3,793	0	1,415	0	0	0	0	0	0	280,361 33
34	Rent-Facility & Grounds	0	(1,297,630)	0	0	0	0	0	0	0	0	0	(1,297,630) 34
35	Rent-Equipment & Vehicles	0	0	11,579	0	0	0	0	0	0	0	0	11,579 35
36	Other (specify):*	(17,347)	63,267	0	0	0	0	0	0	0	0	0	45,920 36
37	TOTAL Ownership	(377,010)	106,111	51,377	0	4,302	5,164	0	0	0	0	0	(210,056) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(81,432)	(108,508)	(240,204)	0	0	0	0	0	(430,144) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(294)	0	0	0	0	0	0	0	0	0	0	(294) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(294)	0	0	(81,432)	(108,508)	(240,204)	0	0	0	0	0	(430,438) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(603,968)	124,842	(469,013)	(90,030)	(60,434)	(235,040)	(16)	(1,344)	0	0	0	(1,335,003) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6L		See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,297,630	Alden-Des Plaines Rehab and Health Care Center, LLC		\$	(1,297,630)	1
2	V	32	Interest income	53,286	Alden-Des Plaines Rehab and Health Care Center, LLC			(53,286)	2
3	V	32	Replacement Reserve interest	342	Alden-Des Plaines Rehab and Health Care Center, LLC			(342)	3
4	V	19	Accounting Fees		Alden-Des Plaines Rehab and Health Care Center, LLC		3,950	3,950	4
5	V	21	Other adminstrative exp		Alden-Des Plaines Rehab and Health Care Center, LLC		1,703	1,703	5
6	V	33	Real estate taxes		Alden-Des Plaines Rehab and Health Care Center, LLC		275,153	275,153	6
7	V	26	Property & liability ins		Alden-Des Plaines Rehab and Health Care Center, LLC		13,078	13,078	7
8	V	32	Interest on mortgage		Alden-Des Plaines Rehab and Health Care Center, LLC		738,011	738,011	8
9	V	32	Interest on IOD loan		Alden-Des Plaines Rehab and Health Care Center, LLC		69,461	69,461	9
10	V	36	Mortgage insurance premium		Alden-Des Plaines Rehab and Health Care Center, LLC		61,954	61,954	10
11	V	30	Depreciation		Alden-Des Plaines Rehab and Health Care Center, LLC		311,477	311,477	11
12	V	36	Amortization		Alden-Des Plaines Rehab and Health Care Center, LLC		1,313	1,313	12
13	V								13
14	Total			\$ 1,351,258			\$ 1,476,100	\$ * 124,842	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	\$ 778,751	Alden Management Services		\$ 5,603	\$ (773,148)	15
16	V	21	Clerical and G & A		Alden Management Services		17,925	17,925	16
17	V	5	Utilities		Alden Management Services		1,583	1,583	17
18	V	6	Maintenance		Alden Management Services		4,729	4,729	18
19	V	24	Travel & seminar		Alden Management Services		6,898	6,898	19
20	V	26	Insurance		Alden Management Services		153	153	20
21	V	20	Dues/subscriptions/fees etc		Alden Management Services		278	278	21
22	V	30	Depreciation		Alden Management Services		9,144	9,144	22
23	V	31	Amortization		Alden Management Services		915	915	23
24	V	33	Real estate taxes		Alden Management Services		3,793	3,793	24
25	V	35	Rent-equipment/vehicles		Alden Management Services		11,579	11,579	25
26	V	32	Interest		Alden Management Services		25,946	25,946	26
27	V	7	Salaries-general serv		Alden Management Services		21,363	21,363	27
28	V	15	Salaries-health care		Alden Management Services		15,975	15,975	28
29	V	27	Salaries-general admin		Alden Management Services		183,854	183,854	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 778,751			\$ 309,738	\$ * (469,013)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube-feeding	\$ 9,600	Pyramid Health Care		\$ 4,411	\$ (5,189)	15
16	V	10	nursing suppliers	75,731	Pyramid Health Care		1,773	(73,958)	16
17	V	39	per diems/other supplies	185,072	Pyramid Health Care		103,640	(81,432)	17
18	V	21	gen'l & admin		Pyramid Health Care		57,145	57,145	18
19	V	27	gen'l & admin salaries		Pyramid Health Care		13,404	13,404	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 270,403			\$ 180,373	\$ * (90,030)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Des Plaines Rehab & HC# 0042010Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	\$ 460,931	Forum Extended Care II		\$ 397,572	\$ (63,359)	15
16	V	10	house stock	3,398	Forum Extended Care II		2,930	(468)	16
17	V	39	I.V.	328,451	Forum Extended Care II		283,302	(45,149)	17
18	V	22	employee benefits		Forum Extended Care II				18
19	V	21	gen'l & admin		Forum Extended Care II		20,762	20,762	19
20	V	32	interest		Forum Extended Care II		1,489	1,489	20
21	V	33	real estate tax		Forum Extended Care II		1,415	1,415	21
22	V	30	depreciation		Forum Extended Care II		1,398	1,398	22
23	V	27	gen'l & admin salaries		Forum Extended Care II		32,178	32,178	23
24	V	10	pharmacy consulting	8,700	Forum Extended Care II			(8,700)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 801,480			\$ 741,046	\$ * (60,434)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Revenue - therapy	\$ 1,400,570	Community Physical Therapy		\$ 1,160,366	\$ (240,204)	15
16	V	32	Interest		Community Physical Therapy		5,164	5,164	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,400,570			\$ 1,165,530	\$ * (235,040)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	\$ 11,437	Alden Bennett Construction		\$ 11,421	\$ (16)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 11,437			\$ 11,421	\$ * (16)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Carpet Cleaning	\$ 6,435	Alden Realty		\$ 5,759	\$ (676)	15
16	V	6	Floor Cleaning	6,860	Alden Realty		6,192	(668)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,295			\$ 11,951	\$ * (1,344)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Note: ANC =	RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
	Name	City		Name	Type of Business
	Alden Nursing Center			The Forum Prof. Center	Office rental
	ANC Lakeland	Chicago		Pyramid Health Care	Nursing supplies
	ANC Long Grove	Long Grove		Forum Extended Care II	Pharmacy
	ANC Heather	Harvey		Alden Management	Management
	ANC Lincoln Park	Chicago		Alden Estates of Evanston	Assisted living
	ANC Waterford	Aurora		Community Physical Thereapy	Therapy provider
	ANC Town Manor	Chicago		Courts of Waterford	Alzheimers unit
	ANC Terrace of McHenry	McHenry		Gardens of Waterford	Assisted living
	ANC Morrow	Chicago			
	ANC Wentworth	Chicago			
	ANC Naperville	Naperville			
	ANC Valley Ridge	Bloomingtondale			
	ANC Village for Children & Young Adults	Bloomingtondale			
	ANC Orland Park	Orland Park			
	ANC Princeton	Chicago			
	Alden of Old Town East	Bloomingtondale			
	Alden of Old Town West	Bloomingtondale			
	Alden Trails	Bloomingtondale			
	Alden Northshore	Skokie			
	ANC Northmoor	Chicago			
	ANC Des Plaines II	Des Plaines			
	ANC Alma Nelson	Rockford			
	ANC Park Stratmoor	Rockford			
	ANC Meadow Park	Clinton, WI			
	ANC Poplar Creek	Hoffman Estates			
	ANC Governor's Park	Barrington			
	ANC Gardens of Rockford	Rockford			

IDPH Facility Number#42010

Reporting Period Beginning1/01/04

Reporting Period Ending12/31/04

Investor List

NAME	
STUART GOLDSAND	4
JULIAN BAILES MD	1
AARON CARL	1
MILDRED SCHLOSSBERG	5
JOHN VERCILLO	3
BRETT CARL	1
FLOYD A. SCHLOSSBERG	37 bought 8
FAS OF PTN	unsold 9
FAS OF CORP	dev. 20
AMS OF PTN (FAS OWNS 'S" CORP	total 37
JOAN/SAM CARL	9 3 Bought 6, Dev total 9
WILLIAM HOLWAY	2
RICHARD KERN TRUST	1
RITCHIE SCHULLO IRA	1
RANDI SCHULLO	2 Dev. 2
JAMES FREY	2
AUDRA ELISCO	1
AMI PISSETZKY	1 LOAN 1
DAVID MENN	1
HERSHEL HERRENDORF	1
HARVEY & MARCIA BRIN	1
LAUREN & TERRY MAGNUSSION	1
JAMES HALLBERG TRUST	3
SCOTT CASTY	10
JOSEPH GARCIA	2
ROBERT & DEANNA CARAS	1
RONALD & ANNETTE CARAS	1
LISA & JEFFREY DELDIN	1
ROSS DEUTSCH	1
JAMIE GOLDSAND-SULLIVAN	1
KENNETH & JERRI SUE GOLDSAND	1
TERI HALL	1
ROBERT HAWORTH	1
GARY & PAULA LEV	2
TOTALS	100

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	37.00	221,996	1.012	2.53	salary	\$ 5,768	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.50	71,686	1.012	2.53	salary	1,863	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.50	48,734	1.012	2.53	salary	1,266	7-7	3
4	Joan Carl d.	Secretary	Vice-President	9.00	221,996	1.012	2.53	salary	5,768	27-7	4
5	Ami Pissetski e.	Financial Service.	Invest/Banking	1.00	203,086	1.012	2.53	salary	5,276	27-7	5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 19,941		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge Realty		X	Mortgage	\$66,537.00	1/1/02	\$ 10,390,300	\$ 10,222,263	6/1/2040	7.2000	\$ 738,011	1							
2	Cambridge Realty		X	Operating loss loan	\$8,538.00	3/1/04	1,690,000	1,678,996	6/1/2040	5.1000	69,461	2							
3				Int exp in excess of CON cap							(206,643)	3							
4	Bank Leumi		X	Working capital	varies	7/30/04	1,150,000	970,000	5/31/2005	varies	51,465	4							
5	Related party-AMS	X		Working capital							1,226	5							
	Working Capital																		
6	Related party-AMS	X		Working capital							25,946	6							
7	Related party-FECII	X		Working capital							1,489	7							
8	Related party-CPT	X		Working capital							5,164	8							
9	TOTAL Facility Related				\$75,075.00		\$ 13,230,300	\$ 12,871,259			\$ 686,119	9							
	B. Non-Facility Related*																		
10	DP Rehab & HCC, LCC	X		Non-care interest income							(342)	10							
11	Patient interest income	X		Non-care interest income							(204)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (546)	14							
15	TOTALS (line 9+line14)						\$ 13,230,300	\$ 12,871,259			\$ 685,573	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 61,954 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$44 For 1998 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

199911,3268

20005,6639

2001112,95810

2002261,77611

2003269,64412

Accrual based on 3% increase over prior year bills.

FOR OHF USE ONLY

13FROM R. E. TAX STATEMENT FOR 2003\$13

14PLUS APPEAL COST FROM LINE 5\$14

15LESS REFUND FROM LINE 6\$15

16AMOUNT TO USE FOR RATE CALCULATION \$16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Des Plaines Rehab & HC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042010

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 586-3883 FAX #: (773) 286-3743

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 09-17-200-128-0000	Nursing home facility	\$ 165,497.75	\$ 165,497.75
2. 09-17-200-129-0000	Nursing home facility	\$ 104,146.43	\$ 104,146.43
3.	Related Party-Alden Mgmt Serv	\$ 149,765.00	\$ 3,793.00
4.	Related Party-Forum	\$ 13,827.00	\$ 1,415.00
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 433,236.18	\$ 274,852.18

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,490 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	51,490	2000	\$ 1,016,045	1
2					2
3	TOTALS	51,490		\$ 1,016,045	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6	110		2000	2000	6,986,060	242,149	40	174,652	(67,497)	810,578	6
7											7
8	Related party-Forum			1978	16,213		22			16,213	8
	Improvement Type**										
9	ISS/Chicago Sound & Communication(vent alarm interface)			2000	3,400	340	10	340		1,587	9
10	Alden Bennett Construction(multiple wireless install)			2001	4,894	489	10	489		1,794	10
11	Owners extras (change orders)			2000	524,876	26,244	20	26,244		115,910	11
12	Owners extras (change orders)			2000	12,972	648	20	648		2,864	12
13	ABC-parking lot sealcoat/stripe			2002	3,852	550	7	550		1,330	13
14	ABC-screened patio enclosure			2002	10,069	1,438	7	1,438		4,076	14
15	EWS Welding-alarm			2002	1,076	108	10	108		323	15
16	New Horizons-residents phones			2002	1,646	165	10	165		439	16
17	New Horizons-residents phones			2002	3,161	316	10	316		817	17
18	ABC-owners extras			2003	2,571	171	15	171		342	18
19	ABC-owners extras			2003	5,511	367	15	367		734	19
20											20
21	GT Mechanical, Inc - Exhaust fan			2004	1,588	146	10	146		146	21
22	ABC-Domestic water booster pump			2004	1,578	92	10	92		92	22
23	GT Mechanical, Inc - H/V/A/C repairs			2004	2,248	112	10	112		112	23
24	Capps Plumbing-line repairs			2004	1,243	21	25	21		21	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,582,958	\$ 273,356		\$ 205,859	\$ (67,497)	\$ 957,378	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	4
5	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	5
6	Leasehold Improvement-Tenant Improvement	1987	996		13			996	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	8
9	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	9
10	Leasehold Improvement-Asphalting	2000	98		3			98	10
11	Leasehold Improvement-DAI	2001	172	17	10	17		54	11
12	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		\$ 7,668,654	\$ 275,745		\$ 208,248	\$ (67,497)	\$ 1,018,807	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$682,526	\$94,583	\$71,146	\$(23,437)	Various	\$312,194	71
72	Current Year Purchases	12,097	1,352	1,352		Various	1,352	72
73	Fully Depreciated Assets	47,882	1,478	1,478		Various	47,882	73
74								74
75	TOTALS	\$742,505	\$97,413	\$73,976	\$(23,437)		\$361,428	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Bus	'01	2001	49,826	9,965	9,965		5	39,861	77
78	Car engine/bus/van	various/dodge	98-'04	8,164	130	130		3	7,981	78
79										79
80	TOTALS			\$57,990	\$10,095	\$10,095	\$		\$47,842	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,485,194	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$383,253	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$292,319	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(90,934)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,428,077	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Ending: 12/31/2004

12.	<u> </u>	<u>/2005</u>	\$ 1812 k	<u> </u>
13.	<u> </u>	<u>/2006</u>	\$ 1836k	<u> </u>
14.	<u> </u>	<u>/2007</u>	\$ 1860k	<u> </u>

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nursing on-site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
		Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 514,003	\$		\$ 514,003	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,226			88,226	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			798,341			798,341	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescripts				352,421		352,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Page 16A				(240,203)	561,457		321,254	13
14	TOTAL			\$		\$ 1,160,367	\$ 913,878		\$ 2,074,245	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Alden Nursing Center - Des Plaines

Page 16A

IDPH Facility Number

#42010

Reporting Period Beginning

1/01/04

Reporting Period Ending

12/31/04

Page 16

Col 5: PT,OT, & ST

Col 6: Other

Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$514,002.87
2. ST	39-3	88,226.05
3.		
4. PT	39-3	798,340.14
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16	460,930.70
Plus: Related Party- Forum Drugs		(63,360.00) see pg 6C support
Plus: Related Party- Forum I.V.		(45,149.00) see pg 6C support
Total to line 9 Pharmacy		352,421.70
10.		
11.		
12. Exceptional Care-Column 3	See pg 16	0.00
12. Exceptional Care-Column 6	See pg 16	0.00
13. Other:Lab,x-ray therapy, mattress, Pyramid billings		642,230.94
Related Party- Pyramid		(81,432.00) see pg 6B support
Related Party- CPT		(240,203.00) see pg 6D support
Oxygen Cost- IDPA		658.36
Total to line 13		321,254.30
14. Total		2,074,245.06

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 75,447	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,351,570	1,351,840	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		300,797	5
6	Prepaid Insurance		42,612	6
7	Other Prepaid Expenses	10,591	10,591	7
8	Accounts Receivable (owners or related parties)		559,936	8
9	Other(specify): Due from Medicare	42,093	42,093	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,404,254	\$ 2,383,316	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		1,388,527	11
12	Long-Term Investments			12
13	Land		1,003,985	13
14	Buildings, at Historical Cost		9,685,956	14
15	Leasehold Improvements, at Historical Cost	583,749	583,749	15
16	Equipment, at Historical Cost	254,964	1,294,881	16
17	Accumulated Depreciation (book methods)	(230,454)	(1,580,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Financing fees		55,407	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 608,259	\$ 12,431,800	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,012,513	\$ 14,815,116	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,442,140	\$ 1,442,140	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	94,917	94,917	28
29	Short-Term Notes Payable	340,388	340,388	29
30	Accrued Salaries Payable	279,534	279,534	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	17,423	17,423	31
32	Accrued Real Estate Taxes(Sch.IX-B)		277,800	32
33	Accrued Interest Payable	37,570	106,039	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr ins/exp/sales tax	49,387	49,387	36
37	Due to affiliates	503,590	503,590	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,764,949	\$ 3,111,218	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	970,000	970,000	39
40	Mortgage Payable		11,901,259	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 970,000	\$ 12,871,259	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,734,949	\$ 15,982,477	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,722,436)	\$ (1,167,361)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,012,513	\$ 14,815,116	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,137,047)	1
2	Restatements (describe):		2
3	External audit adjustment made after 2003 cost report		3
4	was submitted. This has no effect on prior year's report.	1,083	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,135,964)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	413,528	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 413,528	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,722,436)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alden Des Plaines Rehab & HC # 0042010 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,319,392	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,319,392	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	41,691	6
7	Oxygen	1,842	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 43,533	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	713	12
13	Barber and Beauty Care	482	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(4,829)	19
20	Radiology and X-Ray		20
21	Other Medical Services	36,276	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,853	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 204	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Page 19A	2,796	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,796	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,401,778	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,276,596	31
32	Health Care	2,476,928	32
33	General Administration	2,126,291	33
	B. Capital Expense		
34	Ownership	1,543,362	34
	C. Ancillary Expense		
35	Special Cost Centers	2,504,683	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,988,250	40
41	Income before Income Taxes (line 30 minus line 40)**	413,528	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 413,528	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	880	880	\$ 29,104	\$ 33.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,478	26,486	813,348	30.71	3
4	Licensed Practical Nurses	10,872	11,468	276,902	24.15	4
5	Nurse Aides & Orderlies	60,628	63,831	770,337	12.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,786	2,079	33,923	16.32	8
9	Activity Director	1,912	2,072	40,878	19.73	9
10	Activity Assistants	7,170	7,481	82,438	11.02	10
11	Social Service Workers	2,040	2,080	40,678	19.56	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,160	60,805	28.15	13
14	Head Cook	5,571	5,776	75,951	13.15	14
15	Cook Helpers/Assistants	40,817	43,176	380,757	8.82	15
16	Dishwashers					16
17	Maintenance Workers	2,040	2,073	39,669	19.14	17
18	Housekeepers	10,017	10,711	92,958	8.68	18
19	Laundry	3,792	4,085	37,518	9.18	19
20	Administrator	2,785	2,857	124,834	43.69	20
21	Assistant Administrator					21
22	Other Administrative	7,504	7,984	210,454	26.36	22
23	Office Manager					23
24	Clerical	5,643	5,838	59,969	10.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,392	2,432	61,136	25.14	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	416	416	7,605	18.28	31
32	Other Health CaPro-care mgr	1,080	1,120	21,464	19.16	32
33	Other(specify)Clinical SS	2,056	2,080	58,092	27.93	33
34	TOTAL (lines 1 - 33)	196,999	207,085	\$ 3,318,820 *	\$ 16.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,967	1-3	35
36	Medical Director	Monthly	60,067	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly		10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,488	11-3	44
45	Social Service Consultant	13	700	11-3	45
46	Other(specify)				46
47	Alzheimer's Consultant	38	2,073	11-3	47
48					48
49	TOTAL (lines 35 - 48)	97	\$ 72,295		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			B. Ownership %	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Amount	Description	Amount	Description	Amount			
Rosette, Marie	administrator	\$ 124,834	Workers' Compensation Insurance	\$ 94,892	IDPH License Fee	\$			
			Unemployment Compensation Insurance	42,777	Advertising: Employee Recruitment	802			
			FICA Taxes	250,114	Health Care Worker Background Check (Indicate # of checks performed 53)	369			
			Employee Health Insurance	22,756	Surety bond fees	567			
			Employee Meals	19,398	IL Health Care Assoc	4,510			
			Illinois Municipal Retirement Fund (IMRF)*		Ext Care Info Network	184			
			Union health & welfare	62,496	Related party-AMS	278			
			Dental, pension,life	25,053					
			Empl rel/misc p/r/tuition reimb	127					
			Drug tests/401k match/'EE vaccine	6,126					
			Mktg mgr benefit deduction	(19,494)					

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	HVAC compressor	1/2002	\$ 3,063	3	\$	\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,063		\$	\$ 1,021	\$ 1,021	\$ 1,021	\$	\$	\$	\$	\$

Facility Name & ID Number Alden Des Plaines Rehab & HC

0042010

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Health Care Assoc., \$6,355
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,300 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,390
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,398 Has any meal income been offset against related costs? no Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: no The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

IDPH Facility Number #42010

Reporting Period Beginning 1/01/04

Reporting Period Ending 12/31/04

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(19,398)	Employee Meal
	22	19,398	Employee Meal
22		(8,672)	Uniforms
	10	5,683	Uniforms
	6	131	Uniforms
	4	19	Uniforms
	1	996	Uniforms
	3	1,240	Uniforms
	11	117	Uniforms
	21	486	Uniforms
19		0	R/E Tax Appeal
	33	0	R/E Tax Appeal
		<hr/> 0	Net should be 0